State of Kansas Employee Health Plan
Dental Care Coverage Administered by Delta Dental of Kansas, Inc.

Delta Dental of Kansas, Inc. is a member of the Delta Dental Plans Association, the leading and largest underwriter and administrator of group dental coverage in the United States. It is our pleasure to serve as the administrator of the State of Kansas Employee Health Plan's dental care coverage – a benefits plan designed to protect the oral health of you and your covered dependents. Regular preventative dental care not only reduces the cost and discomfort generally associated with extensive dental work, but a healthy mouth contributes to the overall well-being of every person.

Like any provider network arrangement, Delta Dental's participating dentist network is always expanding and changing, therefore a printed directory of dental providers becomes impractical. To verify current participation of a specific dentist, ask your dentist PRIOR to your visit if they participate with Delta Dental. You can also verify the provider's participating status by accessing our website at **www.deltadentalks.com** or by contacting our Customer Service department in the Wichita area at **(316)264-4511**, or toll-free at **(800)234-3375**.

There are network limitations to your dental coverage and not all Delta Dental participating dentists are involved in the Delta Dental PPO program which is part of your coverage. In order to maximize your benefits and receive benefits at the PPO level, please be sure to verify that your dentist is also part of the Delta Dental of Kansas, Inc. PPO panel.

Our website may also be accessed to produce additional Identification Cards for you or your covered dependents, as well as verify coverage status and information. Questions regarding your coverage can be referred to Customer Service through the phone numbers listed above or emailed to **customerservice@deltadentalks.com**.

We look forward to being of service to you and all the members covered by the State of Kansas Employee Health Plan.

BENEFIT DESCRIPTION OF DENTAL CARE COVERAGE

This Benefit Description (hereinafter referenced to as "Plan") is issued on behalf of the State of Kansas by Delta Dental of Kansas, Inc., (hereinafter referenced to as "Delta Dental") a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental program. As defined within this Benefit Description, benefits are limited to the specific listed services and include limitations on specific age and service frequency and/or the amount of allowance for covered items. Members should review this document carefully. These limitations are identified in this Benefit Description.

Only the cost of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are covered dental benefits and then only if identified as a covered dental service in this Benefit Description. Only the Least Expensive Alternative Treatment (LEAT) is covered under this program and then only if identified as a covered dental benefit in this Benefit Description. If either the dentist or the member selects a more expensive service or benefit option, the Plan will pay the applicable percentage of the fee for the Least Expensive Alternative Treatment toward the service provided. The remainder of the fee is not a covered benefit and is Your responsibility. The Dentist and the member, not Delta Dental or the Group, determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

PRE-DETERMINATION OF BENEFITS: ***It is recommended that You ask the Dentist to submit a treatment plan (pre-determination) whenever extensive dental work is being considered***. The Plan will determine the Allowed Amount for covered services and advise the provider. This allows You to plan for the cost of the services that will be Your responsibility to pay. Failure by your Dentist to pre-determine benefits may result in a higher cost to you than anticipated if, in the professional judgment of the Delta Dental consultant, the treatment is not necessary or the Least Expensive Alternative Treatment (LEAT). Even if the Dentist does pre-determine benefits, it does not obligate Delta Dental if You are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Network Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to Delta Dental by the treating Dentist or a new treatment plan should be obtained and resubmitted to Delta Dental.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this booklet, appropriate modifications will be made in the benefits provided.

DEFINITIONS

For the purpose of this Benefit Description, the following definitions shall apply:

Accidental Injury means an unusual and external force applied to the teeth. Accidental injury does **not** include damage to the teeth as a result of biting, chewing, disease or infection.

Allowed Amount means the Maximum Plan Allowance (MPA) for the Least Expensive Alternative Treatment needed to restore the tooth or dental arch to contour and function as determined by the Plan.

Annual Maximum means the maximum benefit payable by the Plan per Member per Plan Year.

Basic Benefit means the benefits that are generally paid for Covered Services. These benefits apply to Members who have not had a routine prophylaxis (cleaning) and/or preventative oral exam in prior twelve (12) months.

Benefit Date means the effective date of the coverage provided by the Group.

Benefit Description means this booklet and any Amendments attached hereto.

Coinsurance means a portion of the Allowed Amount payable by You usually based on a percentage of the Allowed Amount for Covered Services under the terms of the Benefit Description.

Cosmetic Treatment when describing dentistry means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory.

Covered Services are services or supplies provided to You for which the Plan will make payment, as described in this Benefit Description.

Deductible means the amount of Allowable Amount for Covered Services to be paid by a Member before benefits can be provided for a Covered Service. Amounts applied toward the Deductible are accumulated until a specified dollar maximum has been reached during a Calendar Year after which no additional Deductible amount is required for the remainder of that Calendar Year.

Delta Dental PPO Provider means a dental provider who has agreed to render services in accordance with specific terms and conditions of the Delta Dental PPO Network established by Delta Dental.

Delta Dental Premier Provider means a dental provider who has agreed to render services in accordance with specific terms and conditions of the Delta Dental Premier Network established by Delta Dental.

Dental Prosthetics are the devices that replace missing teeth.

Dentist means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.

Dependent is a lawful wife or husband or an unmarried child or step-child of a member's family who meets the eligibility requirements and who is properly enrolled for coverage by the member and on whose behalf premiums are paid by You or the Employer Group.

Enhanced Benefit means the benefits that are paid for Members who have had a routine prophylaxis (cleaning) and/or preventative oral exam in prior twelve (12) months. You will also receive enhanced benefits ninety (90) days following receipt.

Full Mouth Restoration means crowns or restorations on ten (10) or more teeth.

Group means the State of Kansas.

Inlay is an indirect filling pre-made in a dental lab and must be permanently cemented by a dentist. Inlays fit into the space left after a cavity or old filling has been removed.

Intraoral is a complete series of x-rays including a radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

Least Expensive Alternative Treatment (LEAT) means the limitation in this Benefit Description that will only allow benefits for the least expensive treatment.

Maximum Plan Allowance (MPA) means:

a. **Network Dentists** – when services are provided by a Delta Dental PPO or Delta Dental Premier network dentist, the "Maximum Plan Allowance" or "MPA" means the lesser of: 1) the fee submitted by the Delta Dental Network Dentist for the dental procedure, 2) the fee that such Delta Dental Network Dentist has filed with Delta Dental for the dental procedure, if any, or 3) the Delta Dental Network Dentist Maximum Fee.

   The "Delta Dental Network Dentist Maximum Fee" for a Covered Procedure means the fee established by Delta Dental. The Delta Dental Network Dentist Maximum Fee is developed from a number of sources, including but not limited to contracts with dentists, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by dentists in Kansas, and such other information as Delta Dental, in its sole discretion, deems appropriate.

b. **Non Network Dentists** - in the case of Non Network dentists, the MPA means the lesser of: the fee submitted by the Non Network Dentist for the dental procedure, or the Delta Dental Non Network Dentist Maximum Fee.

   The "Delta Dental Non Network Dentist Maximum Fee" for a Covered Procedure means the fee established by Delta Dental from time to time. The Delta Dental Non

Network Dentist Maximum Fee is developed from a number of sources, including but not limited to contracts with dentists, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by dentists in the area of the State in which the services are performed, and such other information as Delta Dental, in its sole discretion, deems appropriate. Generally, the Delta Dental Non Network Dentist Fee will reflect a reduction of the Delta Dental Network Dentist Maximum Fee.

c. **Out of State Dentists** - For services billed by dentists outside the State of Kansas, the Delta Dental Maximum Fee is based on information from the geographic area in which the dentist performs the procedure.

Member means an enrolled participant of the Group who meets and continues to meet all eligibility requirements for participating in the health and dental benefit programs established by the Group.

Non Network Dentist means a dental provider who has not contracted with Delta Dental to participate in the Delta Dental PPO or Delta Dental Premier Networks.

Onlay is an indirect filling which is pre-made in a dental lab and must be permanently cemented by a dentist. An onlay sits on the tooth and builds up its shape.

Panoramic film is a full mouth x-ray.

Plan means all of the covered dental benefits, exclusions and items listed within this Benefit Description that is administered by Delta Dental for the Group.

Plan Year means the time period that begins at 12:01 on January 1 and ends at midnight on December 31 yearly.

Prior Authorization means the Plan has given approval for Covered Services to be performed. Authorization does not guarantee payment. The process includes determination of eligibility, Covered Services, and medical necessity as well as implications about the use of Network and Non Network providers. For services that require prior authorization, failure to obtain the necessary approval will result in the loss of coverage.

Pre-determination of Benefits means prior to performing services, the provider submits to the Plan an itemized bill including the recommended procedures and proposed charges for the procedures being recommended to You. The Plan reviews the submitted services and charges and determines the Allowed Amount for the covered services and advises the provider. A pre-determination does not guarantee payment but does provide You with an estimate of your potential out of pocket expenses.

You or **Your** means the member.

2015 Schedule of Dental Plan Benefits

	PPO Network Provider	Premier Network Provider	*Non Network Provider
Annual Benefit Maximum (including Implant Services)	$1,700 per member		
Lifetime Orthodontic Benefit Maximum	50% Coinsurance to a $1,000 per member		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	$50 per person per Plan Year Not to exceed an annual family Deductible of $150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT **Applies when You have NOT had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior twelve (12) months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
Implant Coverage	50%	50%	50%
ENHANCED BENEFIT **Applies when You have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior twelve (12) months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%
Implant Coverage	50%	50%	50%

* Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.

Your Coinsurance will increase for Basic Restorative Services when You have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, You will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Covered Services

This is a limited benefit policy. Plan benefits are limited to the specific listed services and include limitations on specific age and service frequency. Service frequency is measured from the date of the last service supplied to the member whether or not this plan was effective at the time of the service.

PREVENTIVE SERVICES: The following services are considered Preventive Services by the Plan. Preventive services are not subject to the Annual Benefit Maximum.

- **ROUTINE ORAL EXAMINATIONS AND/OR PROPHYLAXIS:**
  Provides for:
  - Oral examination and/or prophylaxis (cleanings):
    - Covered twice (2) per Member per Plan Year
    - Includes periodontal maintenance
  - Bitewing x-rays:
    - A set is four (4) bitewing x-rays
    - Covered in conjunction with oral exam and/or prophylaxis
    - Two (2) sets of bitewings per Plan Year for Members to age eighteen (18)
    - One (1) set of bitewings per Plan Year for Members age eighteen (18) and over
- **FULL MOUTH X-RAYS**:
  - Panoramic film or Intraoral series
  - Covered once (1) every five (5) years
- **ANCILLARY CARE:**
  - Provides for visits to the dentist for the emergency relief of pain.
- **ADDITIONAL SERVICES FOR MEMBERS WHO ARE CHILDREN:**
  - Topical fluoride for the following:
    - Members to age eighteen (18)
    - Covered twice (2) per Plan Year
  - Space maintainers covered for the following:
    - Members under the age of fifteen (15)
    - The premature loss of primary molars
  - Sealants covered for the following:
    - Members to age eighteen (18)
    - Covered once (1) every four (4) years
    - When applied to permanent molars with no caries (decay) or restorations on the occlusal surface

BASIC RESTORATIVE DENTISTRY: Your Coinsurance will increase for Basic Restorative Services when You have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, You will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall

not include any services provided on an emergency basis or for treatment of an injury to the teeth.

- **FILLINGS:** Provides for amalgam (silver) restorations; composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).
- **ACCIDENTAL INJURIES:** Office visits and x-rays that may be required for diagnosis or treatment of accidental injuries to the teeth when not provided as a part of a routine oral exam or prophylaxis.
- **ORAL SURGERY:** Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.
- **ENDODONTICS:** Includes procedures for root canal treatments and root canal fillings.
- **PERIODONTICS:** Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.

MAJOR RESTORATIVE DENTISTRY:

- **CROWNS:** When teeth cannot be restored with a filling material listed in Basic Restorative Dentistry, provides for gold restorations and individual crowns.
- **PROSTHODONTICS:** Bridges, implants (pre-determination of implants is recommended), partial and complete dentures, including repairs and adjustments.
- **TMJ: Treatment plan must be pre-authorized by Delta Dental.** Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. **Only the following procedures are covered:**
  - 07820–Closed reduction of dislocation
  - 07880–Occlusal Orthotic Device
  - 09951–Occlusal adjustment (limited)
  - 09952–Occlusal adjustment (complete)

Additional Covered Provisions:

a. Benefits are available for a tooth surface only once (1) within a twenty-four (24) month period regardless of the number or combinations of restorations placed therein.

b. Amalgam (silver) restorations and composite (white) resin restorations are covered.

c. Veneers are considered to be optional treatment. Benefit payment will be made for the restorative procedure appropriate to the degree of tooth breakdown.

d. Available benefits for all inlays are on the basis of the Allowed Amount for an equal surface amalgam (silver restoration) with You being responsible for the

difference in cost, if any. Inlays done in place of a filling are eligible once (1) every two (2) years.

e. Payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period on the same tooth.

f. Individual crowns are covered as follows:

(1) Individual crowns and/or Onlays on the same tooth are a covered benefit only once (1) in any five (5) year period. The time period is to be measured from the date the crown or Onlay was supplied to You whether or not this coverage was effective at the time of service.

(2) If a member requires a crown on a tooth that had previously had an Inlay or amalgam or composite restoration within a two (2) year period, the plan will determine the Allowed Amount for the crown by subtracting the amount previously paid for the Inlay or amalgam or composite restoration from the plan allowance for the crown.

(3) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not covered benefits for any person under sixteen (16) years of age.

(4) Recementation of a crown may be allowed for payment only once (1) in a twelve (12) consecutive month period.

(5) Only two (2) repairs per crown will be allowed in a twelve (12) month time period.

(6) Stainless steel crowns are a covered benefit only for dependent children under the age of twelve (12) and are limited to once (1) in a twenty-four (24) month period.

(7) Coverage for core/crown build-ups, including pins is limited to permanent teeth having insufficient tooth structure.

g. Prosthetic appliances are subject to the following limitations:

(1) You are eligible for only one (1) full upper and one (1) full lower denture in any five (5) year period. The time period is to be measured from the date the denture was last supplied to the member whether or not the coverage was effective at the time of service.

(2) You are eligible for a partial denture, fixed bridge, or removable bridge once (1) in any five (5) year period. The time period is to be measured from the date the denture or bridge was last supplied to You whether or not this coverage was effective at the time of service.

(3) Denture reline and rebase (jumps) is a covered benefit only once (1) in any thirty-six (36) month period.

(4) Denture adjustments are a covered benefit only two (2) times in any twelve (12) month period.

(5) No replacement will be made of any existing denture that in the opinion of Delta Dental is satisfactory or can be made satisfactory.

(6) Crowns when used for abutment purposes are covered at the same Coinsurance as provided for bridges and complete and partial dentures.

(7) Recementation of a bridge may be allowed for payment only once (1) in a twelve (12) consecutive month period.

(8) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial towards the procedure submitted. If a fixed bridge, implant or other more expensive procedure is selected, the remainder of the fee is Your responsibility.

(9) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

(10) Benefits for tissue conditioning are limited to no more than two (2) per arch per thirty-six (36) month period.

h. Payment is limited to only once (1) in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis which is payable as a prophylaxis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is covered twice (2) per plan year; and crown lengthening which carries no limitation.

i. Benefits for a seven (7) vertical bitewing series are available once (1) every two (2) years instead of one (1) set of four (4) bitewing x-rays.

j. Recementation of space maintainers are covered one (1) time per lifetime.

k. Sealants are limited to once (1) every four (4) years for dependents to age eighteen (18) and are covered on permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.

l. Coverage for Temporomandibular Joint Dysfunction (TMJ) **MUST BE PRIOR AUTHORIZED** and is limited to the services specified in this section. Intra-oral services which would normally be provided by a licensed dentist in the relief of oral symptoms associated with malfunctions of the TMJ are limited to the following procedures:

07820–Closed reduction of dislocation
07880–Occlusal Orthotic Device
09951–Occlusal adjustment (limited)
09952–Occlusal adjustment (complete)

All services for TMJ will be limited to the annual maximum amount. No further benefits will be provided until five (5) years have passed from the last service in the prior course of treatment.

m. Payment for anesthesia and intravenous (IV) sedation is allowed when provided in the dental office for covered treatment or services only when medically necessary as determined by Delta Dental and not for member convenience and is limited to a maximum of ninety (90) minutes, per episode.

n. Coverage for bone grafts is limited to treatment necessary to maintain natural tooth structure as determined by the Plan. This is a limited benefit and You are encouraged to obtain a pre-determination of coverage prior to obtaining treatment.

IMPLANT COVERAGE: ***This is a limited benefit.***
It is recommended that You ask the Dentist to submit a treatment plan (pre-determination) whenever extensive dental work such as an implant is being considered. This allows You to plan for the cost of the services that will be Your responsibility to pay.

Covered implant services include the following:

- surgical placement of the implant
- implant abutment
- crown or cap on the implant

Other services that may be required for implant placement are not covered by the plan unless specifically states as covered in this benefit description.

All covered services for the placement of implant(s) are subject to 50% Coinsurance and are included in the regular Annual Benefit Maximum of $1,700 per year. You are responsible for any amount above the $1,700 Maximum Plan Benefit in addition to Your Coinsurance. Implants are not covered for members under age sixteen (16).

Care and treatment related to an implant including any related services are limited to once (1) in any five (5) year period. The time period is to be measured from the date the implant procedure was last supplied to You whether or not this coverage was effective at the time of service. The five (5) year limitation on coverage of services will apply even if the member elects to replace the implant with an alternative treatment during this time period.

ORTHODONTIC COVERAGE: Orthodontic treatment including appliances, interceptive and corrective services, is covered at a 50% Coinsurance. Orthodontic treatments are not subject to a Deductible and have a $1,000 per person lifetime

maximum. The lifetime maximum for orthodontic services does not apply to the Annual Benefit Maximum for other covered services.

Payment for orthodontic benefits shall be limited to the maximum per member specified in the Schedule of Dental Plan Benefits. Payment for orthodontic benefits shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist in the treatment plan. The treatment plan with cost estimate must be filed and approved by Delta Dental for payment prior to treatment. Payment of initial fees may be made at the time of treatment. Orthodontic services are covered benefits subject to the following conditions and limitations:

(1) Orthodontic treatment must begin while You are a covered member to be eligible for coverage under this Plan.

(2) The obligation of the Plan ceases if the treatment plan is terminated for any reason.

(3) The Plan's obligation terminates when You are no longer eligible for coverage under the Plan regardless of whether the treatment is completed.

(4) Treatment may be terminated by the Dentist, by written notification to Delta Dental and to You, for lack of member interest and cooperation.

(5) Related services for orthodontic purposes, such as but not limited to, x-rays, extractions, space maintainers, and study models, shall be payable at the orthodontic Coinsurance percentage as specified in the Schedule of Dental Plan Benefits.

(6) The Plan will not pay for the repair or replacement of any orthodontic appliance.

(7) For orthodontic services started prior to January 1, 2006 benefits are covered **only** when provided by a Delta Dental PPO Dentist or a Delta Dental Premier Dentist.

(8) The timely filing for payment of orthodontic services starts with the commencement of work outlined in the treatment plan.

DENTAL ACCIDENT PROVISION: The Dental Accident must occur and treatment received while You are covered under this Plan. Claims for treatment due to an Accidental Injury to the teeth will be processed according to the terms of this Benefit Description except that they will be subject to a limitation of a $5,000 Annual Benefit Maximum. Coverage for treatment of the supporting structure of the teeth, including the jaw, is not covered by this Plan and may be eligible under Your medical coverage. Treatment for Accidental Injury to the teeth must be received within one (1) year of the date of accident in order to be paid under this provision. Treatment received which is not

the direct result of an Accidental Injury will be subject to the Annual Benefit Maximum. The benefits payable for Accidental Injury of the teeth shall be limited to:

a. Examination and diagnosis by a Dentist.

b. Dental x-rays; restorative procedures and applicable oral surgical procedures directly related to the Dental Accident and performed as a result of the Dental Accident.

c. Treatment and replacement, if necessary, of the teeth injured in the Dental Accident.

HOW TO USE YOUR PLAN

Review the Delta Dental PPO and Delta Dental Premier Networks and select a provider. You are free to go to the Dentist of Your choice; however there may be a difference in the amount of payment which will be made by Delta Dental if the Dentist chosen is not a Network Provider. Make an appointment and tell the Dentist office that You are covered by Delta Dental.

DENTIST PAYMENT

Before treatment is started, be sure to discuss with your Dentist the total amount of the bill and the portion, if any, You will be required to pay. Only the Least Expensive Alternative Treatment (LEAT) is covered under this program and then only if identified as a covered dental benefit in this Benefit Description. If either the dentist or the member selects a more expensive service or benefit option, the Plan will pay the applicable percentage of the fee for the Least Expensive Alternative Treatment toward the service provided. The remainder of the fee is not a covered benefit and is Your responsibility. The Dentist and the member, not Delta Dental or the Group, determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

Even if the Dentist does pre-determine benefits, it does not obligate Delta Dental if You are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Network Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to Delta Dental by the treating Dentist or a new treatment plan should be obtained and resubmitted to Delta Dental. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the allocation of payment to each Dentist.

DELTA DENTAL PPO NETWORK DENTIST

Following treatment, the Dentist should forward the claim to Delta Dental. If the Dentist is a Delta Dental PPO Network Dentist, Delta Dental will make direct payment to the Dentist for each covered procedure. Payment will be calculated on the Coinsurance amount identified on the Schedule of Benefits and will be based on the Allowed Amount

for services. You will receive notice of Delta Dental's payment and of the amount, if any, that you owe the Dentist.

DELTA DENTAL PREMIER NETWORK DENTIST

If the Dentist is a Delta Dental Premier Network Dentist, Delta Dental will make direct payment to the Dentist for each covered procedure. Payment will be calculated on the Coinsurance amount identified on the Schedule of Benefits and will be based on the Allowed Charge for services. You will receive notice of Delta Dentals payment and of the amount, if any, that you owe the Dentist.

NON NETWORK DENTIST

For dental benefits and services provided by a Non Network Dentist, Delta Dental will determine the amount payable subject to the Allowed Amount and applicable Deductible and Coinsurance. This amount will be paid to You.

EMERGENCY TREATMENT

The Plan's coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and members should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours.

TREATMENT OUTSIDE OF THE UNITED STATES

To claim dental care received outside of the United States, You must present proper documentation and records for consideration. You will be responsible for obtaining documentation that includes but is not limited to: an itemized statement of the treatment provided that includes the member's name, date of service and a description of the services and the cost for which You are responsible. You are responsible for providing an English translation of the claim and the currency exchange rate for the date of service listed on the claim. X-rays or other supporting documentation may also be required. All Plan limitations and exclusions apply. Only services that are eligible for coverage under this Plan will be considered for payment.

EXCLUSIONS AND LIMITATIONS

1. **The Dental Benefits and Services Provided Shall <u>NOT</u> Include The Following:**

    a. Coverage for any member who has been, but no longer is, an Eligible Person.

    b. Any service that is not specifically provided under the Benefit Description of Dental Care Coverage.

    c. Appliances for treatment of or restorations for replacing tooth structure lost by attrition, grinding, abrasion, bruxism, erosion or abfractions.

d. Benefits or services for control of harmful habits to include but not limited to tooth grinding.

e. Benefits or services which are determined by Delta Dental to be Cosmetic Treatment including surgery; or, dentistry for Cosmetic reasons.

f. Prescription drugs, premedications and relative analgesia; hospital, healthcare facility, or laboratory charges; general anesthesia for restorative dentistry shown; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.

g. Benefits and services that are not necessary and customary as determined by the standards of generally accepted dental practice.

h. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

i. Appliances or restorations for altering vertical dimension, for restoring occlusion, for aesthetic purposes; splinting or equilibration.

j. Services performed for the purpose of full mouth reconstruction.

k. Dental care injuries or disease caused by participation in acts of violence if the member was an active participant therein including but not limited to fighting, riots or any form of civil disobedience; war or act of war; injuries sustained while in the act of committing a criminal act; injuries intentionally self-inflicted.

l. Injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting there from.

m. Except in the treatment of accidental dental injuries, temporary services and procedures, including, but not limited to, temporary fillings, sedative fillings and bases, temporary crowns and temporary prosthetic devices.

n. Treatment, services and appliances for banding related to orthodontics started prior to the date You became an Eligible Person.

o. Crowns and endodontic treatment in conjunction with an overdenture.

p. Replacement of lost or stolen dentures or charges for duplicate dentures.

q. Member education services.

r. Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident to the extent such benefits and services are payable under any medical or dental expense payment provision (by whatever terminology used -- including such benefits mandated by law) of any automobile insurance

policy. The excluded expenses cannot be used for any purpose under the Benefit Description of Dental Care Coverage.

s. Any benefit, procedure or service, for which the motivating purpose is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when the prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

t. The Plan does not warranty or guarantee services provided by Your dentist and is not responsible for paying for the repair or replacement of services which are determined to be substandard.

u. Services or supplies for which no charge is normally made are not covered.

v. Cost for preparation or copying of dental claim forms, records or duplication of x-rays.

w. X-rays taken in conjunction with non-covered services.

x. Implant/abutment for support of a removable or fixed denture; abutment supported retainer; services for repair of or removal of implants.

y. Benefits for fixed appliances and restorations for TMJ care or treatment. Repair or replacement of any appliances furnished in whole or in part for TMJ care or treatment.

z. Surgical treatment of TMJ including ancillary care, such as anesthesia and hospital stays.

aa. Diagnostic procedures not otherwise specified as covered under this contract are excluded.

bb. Bone grafts for the repair or restoration of the jaw or other structures not otherwise specified as covered under this contract are excluded.

cc. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges started prior to the date You became an Eligible Person.

dd. Dental benefits and services which are not completed.

GENERAL INFORMATION

TIMELY FILING REQUIREMENTS

Notice of Your claim must be given to Delta Dental within ninety (90) days after You receive service. You are responsible for making sure the Dentist knows You are eligible

under the program and submits the claim to Delta Dental. If a Non Network Dentist does not submit a claim for You, You must do so Yourself. If You need help submitting a claim, call or write Delta Dental.

If it is not reasonably possible for You to submit a claim within ninety (90) days after receiving services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by Delta Dental within one (1) year and ninety (90) days after You receive services.

REQUEST FOR ADDITIONAL INFORMATION

In order to process Your claim, there may be an occasion when additional information is needed. You have ninety (90) days from the date this information is requested to furnish this additional information. If the additional information is not received by Delta Dental within ninety (90) days following the request, the claim will be denied.

CLAIMS AND APPEALS

1. Purpose.

Delta Dental recognizes that from time to time members may encounter challenging situations where additional review may be desired. When this occurs, You and Your dentist are encouraged to contact Delta Dental. It is the policy of Delta Dental to promptly and fairly consider all Claims and Appeals of its members. This section outlines the procedures for and the time periods applicable to claim decisions and appeal decisions for pre-determinations and post-service claims. It is the policy of Delta Dental to afford members a full and fair review of claim and appeal decisions.

2. Claims and Appeals Procedures.

a. **Definitions.** For the purpose of this Claims Procedures Section, the following terms and their definitions apply:

(1) **Adverse Decision** means a denial in whole or in part of a pre-determination or a post-service claim and for which You are financially responsible or, for a pre-determination, for which You would be financially responsible, if You obtained the service.

(2) **Appeal** means a written request for review of an adverse decision that is submitted to Delta Dental by the member. All appeals must be in writing and sent to Delta Dental, P.O. Box 789769, Wichita, Kansas 67278-9769.

(3) **Claim for Benefits or Claim** means a written request for benefit made by the member in accordance with Delta Dental's procedure for filing claims. A claim includes both pre-determinations and post-service claims. A claim must be in writing and have sufficient

information upon which to base a decision regarding benefits according to all of the provisions of the Benefit Description, including but not limited to the following information:

A. Group number and member identification number;
B. Member Name and Birth date;
C. Dentist Name and License Number;
D. Claim Number;
E. Date(s) of Service.

(4) **Pre-determinations** means a request for a claims decision when prior authorization of the services is required by Delta Dental or requested by the member. Requests for advance information on Delta Dental's possible coverage of services or advance approval of covered items or services do not constitute pre-determinations.

(5) **Post-Service Claim** means a request for a claims decision for services that have been provided.

b. **Initial Claim Decisions.** Normally, members will receive a written acknowledgement to their claims within twenty (20) days of receipt unless referred to a review committee or other unusual circumstances arise, in which case the member will be advised and an answer or decision should be received in writing within thirty (30) days of receipt.

c. **Regional Dental Consultant.** Delta Dental is aware that the review of a claim form and x-rays may not be sufficient to come to a decision in all cases. If Delta Dental determines additional review is needed, Delta Dental may rely on the council of regional dental consultants to examine members clinically. The treating dentist is notified by Delta Dental if a member is being selected for examination by a regional dental consultant. Routine pre- and post-treatment examinations may be made to determine contractual benefits and to verify that the treatment was provided and meets the accepted standards of the profession.

d. **Appeal of Initial Adverse Decisions (first level appeal).** A member has the right to appeal the initial adverse decision. This is a first level appeal. The first level appeal will be coordinated and the determination made by a representative of Delta Dental. If the member desires additional review of the claim, a second level appeal can be requested.

The time periods that apply for appeal decisions are as follows:

Action	**Pre-Service Claim**	**Post-Service Claim**
Time to file first level appeal (from the date Delta Dental made the initial adverse	180 days	180 days

decision)		
First level appeal decision from Delta Dental (from the date the appeal is received by Delta Dental)	15 days	30 days

e. **Appeal of adverse decisions from a first level appeal (second level appeal).** A member has the right to appeal an adverse decision from a first level appeal. This is a second level appeal. A second level appeal will be coordinated by Delta Dental and the determination made by the Group. The decision on the second level appeal is final.

The time periods that apply to second level appeal decisions are as follows:

Action	Pre-Service Claim	Post-Service Claim
Time to file second level appeal (from the date Delta Dental made the adverse decision on the first level appeal)	90 days	90 days
Second level appeal decision (from the date the appeal is received by the Group)	15 days	30 days

PLAN LIABILITY

Delta Dental shall have no liability for any conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omission, or any other act, of any person, including but not limited to employees, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services, and shall also have no liability for any services or facilities which, for any reason, are unavailable to You.

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, Delta Dental, upon its request, shall be entitled to receive from any attending or examining Dentist, or from hospitals in which a Dentist's care is rendered, such information and records relating to Your attendance to, or examination, or treatment rendered to You as is needed in the administration of such claims. Delta Dental, at its own expense, shall have the right and opportunity to require You to be examined when and as often as it reasonably requires during the pending of a claim under this Benefit Description and the right and opportunity to make an autopsy if it is not prohibited by law. The accepting by You of any benefit of coverage under this Benefit Description constitutes the automatic and irrevocable consent by You and the Provider of service for the release to Delta Dental of any and all of the information and records before described, and a full waiver by You that any of such information and records that otherwise is privileged.

CONFIDENTIALITY

Delta Dental agrees that it has individual health information and other proprietary information (collectively, "Information") which is valuable, special, private, and unique. Delta Dental will not divulge, disclose or communicate in any manner any Information to any third party without prior written consent of the member. Delta Dental will protect the Information and treat it as strictly confidential.

MISREPRESENTATIONS

No statements made by the Group or by an individual employee shall be deemed warranties, and no statement by the Group or employee shall be used in defense of a claim or in any other dispute under the Benefit Description, unless it is contained in a written instrument, a copy of which has been furnished to, the Group, employee or personal representative thereof and, if such statement was made in the application of this Benefit Description, which application or an exact copy thereof is included in or attached to this document.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Benefit Description prior to the expiration of sixty (60) days after final notice of claims has been filed in accordance with the requirements of the Benefit Description nor shall any action be brought after five (5) years from the date the claim for benefits was presented to the Plan.

GOVERNING LAW

The entire Benefit Description document shall be interpreted and enforced according to applicable laws of the State of Kansas and the Public Health Service Act, except to the extent such laws are preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

ELIGIBILITY OF MEMBERS AND THEIR DEPENDENTS

a. Eligibility is determined by the Group.

b. At termination of coverage under this Plan, operative procedures then in progress which are completed within thirty (30) days of the termination of coverage and submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges and are considered in progress only if all procedures for commencement of lab work have been completed.

COORDINATION OF BENEFITS (COB)

a. For purposes of this section, "This Plan" means that portion of the Benefit Description that provides the benefits that are subject to this provision. "This Plan"

will not duplicate benefits for dental care service for which You are entitled under any of the following plans:

(1) Group, blanket, or franchise insurance.
(2) Group practice, individual practice, and other prepayment of coverage on a group basis. (This includes group contracts issued by the Plan).
(3) Labor-management trusted plans.
(4) Union Welfare plans.
(5) Employee benefit organization programs.
(6) Coverage under government programs.

b. **Order of Benefit Determination Rules**
When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays benefits before another plan is the rule to use.

A. Non Dependent or Dependent – The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare Beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. retiree employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

B. Child Covered Under More Than One (1) Plan – The order of benefits when a child is covered by more than One (1) Plan is:

1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
   - The parents are married;
   - The parents are not separated (whether or not they ever have been married); or
   - A court decree awards joint custody without specifying that one (1) party has the responsibility to provide health care coverage.

2. If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination period or plan years commencing after the plan is given notice of the court decree.

3. If the parents, are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
   - The plan of the custodial parent;
   - The plan of the spouse of the custodial parent;
   - The plan of the non custodial parent; and then
   - The plan of the spouse of the non custodial parent.

C. Active or Inactive Employee – The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule b (1).

D. Continuation Coverage – If a person whose coverage is provided under a right of continuation provided for by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as the person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

E. Longer or Shorter Length of Coverage – The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

F. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been primary.

c. **Effect On The Benefits Of This Plan**
When this Plan is secondary, it may reduce its benefits so that the total benefit paid or provided by all plans are not more than 100% of the total allowable expenses.

d. **Right to Receive and Release Needed Information**
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Delta Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person's claim benefits. Delta Dental need not tell, or get the consent of any person to do this. Each person's claim benefits under this Plan

must give Delta Dental any facts it needs to apply those rules and determine benefits payable.

e. **Facility Of Payment**
A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Delta Dental may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

f. **Right Of Recovery**
If the amount of the payments made by Delta Dental are more than it should have paid under this COB provision, it may recover the excess from one (1) or more of the persons it has paid or for whom it has paid; or another person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

FRAUDULENT, GROSS MISBEHAVIOR OR MISREPRESENTATION

You and Your dependent(s) coverage may be terminated and other appropriate action taken as determined by the Group, if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Group. This includes but is not limited to:

a. Any member and/or dependent who misrepresents or omits material facts to include the unauthorized use of a dental plan identification card to obtain supplies or services, which are not prescribed or ordered for the member and/or dependent or which the member and/or dependent is otherwise not entitled to receive may result in the termination of Your coverage and that of Your dependents by the Group and any other action determined appropriate by the Group.

b. A member and/or dependent who permits the unauthorized use of a dental plan identification card for any person not covered under the Plan to obtain supplies or services in which they were not otherwise entitled to receive may result in the termination of Your coverage and that of Your dependents by the Group and any other action determined appropriate by the Group.

c. Using another State of Kansas member's Dental Plan identification card to obtain medication, services or supplies for Your or some other third party not specifically covered under that membership may result in the termination of Your coverage and that of Your dependents by the Group and any other action determined appropriate by the Group.

d. Any other improper action as determined by the Group.

DELTA DENTAL OF KANSAS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:
Privacy Officer
Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769
(316) 264-1099 or (800) 733-5823

Delta Dental of Kansas, Inc. (the "Plan") is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan's payment to pay you or your health care provider for covered expenses. Activities associated with payment include, but are not limited to, enrollment activities; collection of contributions from you and your employer; payment for covered expenses, including coordination of benefits; review of payment decisions upon appeal; activities related to pre-authorization of benefits and utilization review; and disclosure of contribution payment history to a consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not limited to, activities necessary to reduce overall health care costs; contacting you or your health care provider about alternative treatments; evaluating practitioner and provider performance; training of non-health care professionals; activities related to obtaining an insurance contract, such as census rating for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud and abuse detection and compliance-related activities; analysis related to managing and operating the Plan; development or change of payment methods or coverage policies; and educational activities.

Under applicable federal law, there are other uses and disclosures the Plan may make without your specific authorization some are included below:

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected information only to the minimal extent it helps your employer administer the program, such as providing billing information, and confirmation of enrollment. The employer must limit its use of that information to obtaining quotes or modifying, amending, or terminating the Plan.

Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.

Furnishing data to Business Associates. The Plan's Business Associates (e.g., printers, mailing services, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

Uses and disclosures required by law. The Plan will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

Disclosures for public health activities. We may disclose your protected health information for the following public health activities in circumstances that would help prevent or control disease, report child abuse, and domestic violence. Such disclosure will be made only to extent required by law or with your agreement.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official's request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

Other Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization.

Furthermore, while the Plan does not typically use or disclose your protected health information for marketing purposes; sell your protected health information for direct or indirect financial benefit or non-financial benefit (i.e. in-kind item or service); or retain, use or disclose psychotherapy notes, if the Plan does intend to engage in such activity, your authorization will be obtained as required by law prior to engaging in said activity.

If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, http://www.deltadentalks.com.

Right to Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

The effective date of this Notice is September 23, 2013. The Plan reserve the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.

THIS PAGE LEFT INTENTIONALLY BLANK